

GILLETTE, (W.R.)

(From the Transactions of the New York Obstetrical Society.)

A NEW OPERATION

FOR THE

CURE OF RECTOCELE AND CYSTOCELE.

BY

DR. W. R. GILLETTE.

VISITING PHYSICIAN TO CHARITY AND ST. FRANCIS HOSPITALS

*Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF
WOMEN AND CHILDREN, Vol. X, No. II., April, 1877.*



NEW YORK:

WILLIAM WOOD & CO., 27 GREAT JONES STREET.

1877.

(From the Transactions of the New York Obstetrical Society.)

A NEW OPERATION

FOR THE

CURE OF RECTOCELE AND CYSTOCELE.

BY

DR. W. R. GILLETTE. ✓

✓ VISITING PHYSICIAN TO CHARITY AND ST. FRANCIS HOSPITALS.

*Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF
WOMEN AND CHILDREN, Vol. X., No. II., April, 1877.*



NEW YORK:

WILLIAM WOOD & CO., 27 GREAT JONES STREET.

1877.

A NEW OPERATION

FOR THE

CURE OF RECTOCELE AND CYSTOCELE.

BY

WALTER R. GILLETTE, M.D.,

VISITING PHYSICIAN TO CHARITY AND ST. FRANCIS HOSPITALS.

"THE operations for the cure of those distressing conditions, rectocele and cystocele, are tolerably familiar to the profession, not however, in the sense that they are operations which, as at present devised, may be performed by the general practitioner. On the contrary, admirable as are the methods of operating for the cure of this condition, known as Sims's, Emmet's, Thomas's, Peaslee's, and Noeggerath's, they are of extreme difficulty of performance by the general surgeon, and require, as we all know, a high degree of skilled and expert labor to perform them at all successfully. These operations, therefore, which by the necessity of their ingenuity, are confined to a few skilful gynecologists, must limit their beneficial results to a very few who are suffering from these conditions.

The operation I present is an extremely simple one, and one which in another form of disorder is familiar to every one in the profession—namely, the ligation of hemorrhoidal tumors. Exactly the same principle and methods of relief and cure are presented in the one as in the other. I have operated seven times for rectocele and cystocele by this method of ligation within the last three months, and with such gratifying results that I do not hesitate to recommend this operation as one which may be done with as good a promise of cure as can be offered by any method, and with much greater facility and celerity, with less loss of blood (indeed it may be said to be a bloodless operation) than any.

I have operated five times for the cure of rectocele, and twice for the cure of cystocele.

The operation for the cure of rectocele is as follows: The patient is to be prepared by simply evacuating the rectum and the bladder; anæsthetized, and placed in the 'lithotomy' position.

The rectocele is then to be seized with a tenaculum or vulsellum forceps, and dragged outwards and upwards. Thus held, it is handed to an assistant with directions to keep it in position. The index finger of the left hand is now passed into the rectum as a guide, over which the needle, threaded, is to pass. An ordinary straight needle, two inches long, is to be threaded, with a heavy, twisted, double ligature, and entered laterally to the mass, at the point of its widest diameter, passed carefully in a direction from left to right in the cellular tissue, between the vagina and rectum, and made to emerge directly opposite to the point of entrance. This step of the operation is the only one in which downright care or solicitude need be exercised, for it would be extremely disastrous if, in passing this needle and ligature, a portion of the rectum were to be caught, insomuch as recto-vaginal fistula would be sure to follow. There is no danger of this if the finger in the rectum does its intelligent duty as a guide, for the intercellular connections between the vagina and rectum are extremely loose and abundant, and there is no difficulty in passing the needle safely, with a very little care.

The needle now having been passed through, the ligature is cut close to the eye, and the vaginal mass is ready to be ligated in two equal halves. This must be done with sufficient effect to insure the complete strangulations of the parts. To this end the lower half of the mass is tied as tightly as possible, and we must be certain, before securing the ligature by the final knot, that the mass is dying, by the evidences of its becoming purple and cold. The upper mass is to be treated in the same way. The tenaculum or vulsellum forceps is now to be removed, and the parts allowed to drop back in their place.

The operation upon cystocele is almost exactly similar, except that the patient is to be put in the semi-prone (Sims's) position, and the needle passed with the greatest possible care, so as not to include the walls of the bladder. It is best to transfix with the needle, and then, before drawing through the ligatures, carefully examine with a probe, or sound, in the bladder along the course of the needle, whether any metallic substance can be felt. This is the way I have operated; but to be still more secure or confident the finger may be passed through the urethra, into the bladder, and the needle passed over it as a guide, just as in the operation for rectocele, the finger in the rectum was used as a guide. I believe Dr. Noeggerath operated recently in this way.

I have found that so much effort has to be made to secure the masses tightly, that hereafter I shall operate on large tu-

mors by passing the double ligature to and fro three times, so as to ligate the mass in four sections.

Thus *tumor* will represent the part to be removed, with the double ligature transfixing it in three sections. (Fig. 1.) Cutting the ligatures at the points of emergence, will permit me to tie as indicated in Fig. 2.

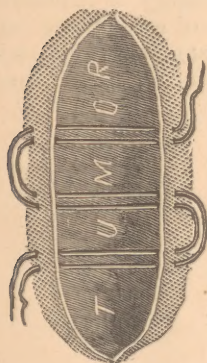


FIG. 1.

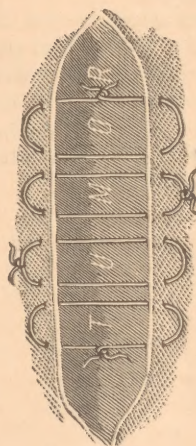


FIG. 2.

The patient is now to be put to bed, and an opiate administered, if necessary. It will not often be required if the masses have been properly tied—that is, if they have been utterly destroyed by their circulation being strangulated. In one case where I did not tie sufficiently tight, there was considerable pain, which, however, was relieved by at once ligating the masses again, and securely.

The patient is to be permitted to have her evacuations from the bowel or bladder, naturally, and so far I have only seen one case where the catheter was requisite.

After-Treatment.—The vagina is to be syringed, as often as may be necessary, with carbolized water, to insure cleanliness. In the course of from four to seven days the masses drop off, leaving the stumps to heal by granulation. This they do in the course of from two to four weeks. I speak only from my experience with patients who would not remain in bed, but who insisted upon getting up and going about as soon as the masses sloughed off. I think they would have healed much more rapidly if I could have kept them in bed.

The operation thus performed will be seen to be exactly similar to that for the removal of hemorrhoidal tumors by

transfixion and ligation, and like it, is extremely simple of performance. It requires, after the patient has become anæsthetized, but a few minutes of time for its completion. It is almost bloodless, and accompanied by no more danger than the ordinary hemorrhoidal operation. The cases operated upon have been under my observation, and so far as I can foresee are successful.

The operation is not designed to overcome those extreme cases where the hernial protrusion of the vagina is due to a loss of the perineum, and where perineorrhaphy is necessary to a permanent cure, but in the latter class of cases there can be no objection to supplementing the treatment by ligation, with that of the rational and standard operation for the restoration of the lost perineal body."



